088641

B-164031(4)
12-4-70

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(4)

RELEASED

DEC 4 1970

088641

ELOISE

Dear Mr. Chairman:

Sen. - Senate

Pursuant to your request of May 7, 1970 (encl. II), we are submitting a report (encl. I) on our review of Medicare payments made by Michigan Medical Service (Blue Shield) for the services of salaried supervisory and teaching physicians at Wayne County General Hospital in Eloise, Michigan. The physicians involved were county employees who were paid annual salaries by the hospital. The hospital is affiliated with the University of Michigan and Wayne State University medical schools which provide training to residents, interns, and medical students at the hospital. The Medicare payments discussed in this fourth report submitted pursuant to your request were made under the Supplementary Medical Insurance Benefits for the Aged (part B) portion of the Medicare program.

The Medicare program is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare, which has entered into contracts with various private insurance companies, such as Blue Shield organizations, to make benefit payments for physicians' services.

Following is a summary of the information that we obtained at the hospital relating to the points of interest specified in your letter of May 7. These matters are discussed in more detail in enclosure I on the cited page references.

--From March 1967 through June 1969, the hospital received about $371,000 in part B Medicare payments for the services of its salaried physicians. These salaried physicians involved (1) supervisory and teaching physicians who supervised the medical care provided in the hospital wards and operating rooms and (2) specialists such as radiologists and pathologists. The payments related to services provided since July 1966. The bills for the services of the supervisory and teaching physicians were on a fee-for-service basis and were submitted by the hospital in the names of specific physicians for specific medical and surgical services provided to specific Medicare patients. (See pp. 3 to 5.)

913677

--Our comparison of claims paid by Blue Shield with the medical records applicable to 50 Medicare patients indicated that the professional services, for which bills on a fee-for-service basis had been made by the hospital on behalf of its supervisory physicians, generally had been provided by residents and interns and not by supervisory physicians. Services provided by residents and interns were not eligible for billing on a fee-for-service basis under part B of the Medicare program, but the salaries of the residents and interns were reimbursable to the hospital under the Hospital Insurance for the Aged (part A) portion of the Medicare program. In addition, a portion of the salary costs applicable to certain administrative, teaching, and supervisory activities of the supervisory physicians were also reimbursable to the hospital under part A. If reimbursement were to be made under both parts A and B for the same services, the Medicare program would be paying for such services twice.

According to the hospital's medical records for the 50 patients, supervisory and teaching physicians were involved in providing about 4 percent of the number of services for which charges for daily hospital visits had been billed in their names. Also, for eight of the 28 bills for surgery included in our sample, the medical records did not indicate the presence of supervisory physicians during the surgery which had been performed by residents. (See pp. 6 to 11.)

--On the basis of claims submitted by Wayne County General Hospital for reimbursement under part A of the Medicare program, we estimate that the amounts claimed under part A and the $371,000 paid under part B for the services of all its salaried physicians exceeded the hospital's reimbursable costs by as much as $115,000 for the 3-year period ended June 30, 1969.

The hospital and Blue Shield advised us that the accuracy of the hospital's claims for reimbursement under part A of the program was questionable and that they were awaiting the completion of an audit by the part A intermediary (Blue Cross) to

resolve this problem. We believe that, in making a final determination of the Medicare reimbursement to Wayne County General Hospital under both parts A and B of the program, the part B payment already received by the hospital should be considered and any excess payments should be recovered. (See pp. 14 to 16.)

--In April 1964, the Wayne County Board of Supervisors established a fund designated as the Wayne County General Hospital Medical Staff Research and Development Fund. The amounts collected under part B of the Medicare program, together with amounts collected under private medical insurance for the professional fees of the hospital's physicians, were initially deposited with the county. The county distributed the funds annually--the first $70,000 to the hospital research and development fund and the next $180,000 to the county; any remaining balance was to be distributed in the ratio of 40 percent to the research and development fund and 60 percent to the county. (See pp. 4 and 5.)

--The hospital has attempted to collect the deductible and coinsurance portions of the physicians' charges from the Medicare patients. The 50 patients included in our review were responsible for paying deductibles and coinsurance amounting to $2,215 of the charges of $8,934 allowed by Blue Shield for daily medical care, surgery, and consultations. As of May 1, 1970, $1,469 or about 65 percent of the $2,215 had been collected by the hospital, principally from the Medicaid program and from Blue Shield under its private insurance policies that supplemented Medicare. Because the Medicare patients, at the time of admission, authorized the hospital to bill for any benefits due on their behalf, the patients were not required under SSA regulations to sign each bill authorizing payment to be made to the hospital for the services of specific physicians. The Medicare patients, however, were notified by Blue Shield of payments made on their behalf. (See pp. 17 and 18.)

--The hospital's charges under part B of the Medicare program for the professional services of its salaried supervisory and teaching physicians were based on certain fee schedules. (See pp. 3 and 4.) We believe--and SSA and Blue Shield agree--that, on the basis of their acceptance of the results of our review of the hospital's medical records, the use of these fee schedules was not appropriate because it was questionable whether many of the services billed had been personally furnished by the physicians in whose names the bills had been submitted. Blue Shield also advised us that it had concluded that a more appropriate payment mechanism for physicians' professional services at the hospital would be a per diem rate. We believe that, if such a per diem rate were based on the hospital's cost of providing the services, the payment method favored by Blue Shield would be a reasonable one. (See pp. 12 and 13.)

--The hospital has billed private insurance companies on a fee-for-service basis for the services of its supervisory and teaching physicians since before the effective date of the Medicare program (July 1966). Also, beginning in January 1969, the hospital billed the Medicaid program on a fee-for-service basis for physicians' services to patients eligible for assistance under that program. Our test of bills showed that the hospital's fees to private insurers were comparable to the fees that Medicare had been billed for like services and that, in most cases, the private insurers had honored the claims. (See p. 19.)

--After the issuance of SSA's April 1969 guidelines which set forth more clearly the circumstances under which Medicare payments for services provided by supervisory and teaching physicians could be made, Blue Shield, in August 1969, curtailed part B payments to 16 hospitals in Michigan, including Wayne County General Hospital. In December 1969, Blue Shield made an audit at Wayne County General Hospital and concluded that the hospital was not complying with the revised guidelines

because 74 of the 100 medical records reviewed by Blue Shield did not support the related bills. As of October 1, 1970, Blue Shield had not resumed part B payments to the hospital. (See pp. 11 and 12.)

On May 21, 1970, the House of Representatives passed House bill 17550 entitled "Social Security Amendments of 1970." One of the provisions of the bill would change the basis for reimbursement for services provided by supervisory and teaching physicians under part B of the Medicare program from a fee-for-service basis to a cost-reimbursement basis when the physicians' services are provided in a setting containing either of the following circumstances:

--The non-Medicare patients, even when able to pay, are not obligated to pay the billed charges for physicians' services.

--Some or all of the Medicare patients do not pay the deductible and coinsurance amounts related to the physicians' charges or such payments are not made on their behalf.

Under the bill, the cost reimbursement would be 100 percent of the reasonable costs of such services to the hospital or other medical service organization, including medical schools. It would therefore be unnecessary for those institutions to obtain the deductible and coinsurance amounts from the individual Medicare beneficiaries. According to the report of the Committee on Ways and Means (H. Rept. 91-1096) which accompanied the bill, the cost-reimbursement approach would ensure equitable payment and no loss to the hospitals for services provided to Medicare patients and would also simplify billing.

We believe that our report will be of interest to your Committee in its consideration of the supervisory and teaching physicians' provisions of House bill 17550, because it presents an actual situation in which services provided by physicians at a hospital could be paid for on a fee-for-service basis under the House bill, but where, in our

opinion, a cost-reimbursement method may be more appropriate under the various requirements contained in existing SSA regulations.

As stated previously, private insurers have paid the hospital's charges for the professional services provided by its supervisory physicians to individual patients; therefore, the hospital could meet the condition in the House bill that, to bill Medicare on a fee-for-service basis, non-Medicare patients must be obligated to pay the billed charges for physicians' services. Because the deductible and coinsurance amounts applicable to Medicare patients have been billed by Wayne County General Hospital and in many cases have been paid by the Medicaid program or by private insurers under their medical insurance policies that supplement Medicare, the hospital would also be eligible for this reason to bill Medicare on a fee-for-service basis under the House bill.

Under existing SSA regulations, however, we believe that the fee-for-service basis used by Blue Shield in reimbursing Wayne County General Hospital was not an appropriate method of paying for the services of the supervisory and teaching physicians at the hospital because (1) according to the hospital's medical records, the specific services for which payments were made had been generally performed by only residents and interns whose salaries were reimbursable to the hospital under part A and (2) in most cases, the medical records lacked documentation to establish that the Medicare patients had an attending supervisory physician who exercised full personal control over the care of the patient during the period of his hospitalization.

In view of the foregoing factors, we believe that the application of the cost-reimbursement method for reimbursing hospitals for services provided by supervisory and teaching physicians in a teaching setting may be less costly to the program and less burdensome to administer, particularly in such situations as those at Wayne County General Hospital where the physicians are salaried employees of a hospital and the hospital is reimbursed for a variety of services provided by these physicians, including some services which may be reimbursable under

part A and other services which may be reimbursable under part B of the Medicare program.

The matters discussed in enclosure I were presented to SSA, Blue Shield, and the hospital for review. Their written comments were considered by us in the preparation of our report. The hospital stated that the absence of documentation in the medical records for services provided by supervisory and teaching physicians for which bills had been submitted by the hospital did not mean that these services had not actually been provided by the physicians.

Pursuant to agreements with the Committee, copies of this report are being sent to the Secretary of Health, Education, and Welfare and the Commissioner of Social Security. A similar report is being sent to the Chairman of the Committee on Ways and Means, House of Representatives.

Sincerely yours,

Comptroller General
of the United States

Enclosures - 2

The Honorable Russell B. Long
Chairman, Committee on Finance
United States Senate

GENERAL ACCOUNTING OFFICE

EXAMINATION INTO MEDICARE PAYMENTS FOR SERVICES OF SALARIED SUPERVISORY AND TEACHING PHYSICIANS AT WAYNE COUNTY GENERAL HOSPITAL, ELOISE, MICHIGAN

MEDICARE PROGRAM

The Medicare health insurance program was established under title XVIII of the Social Security Act (42 U.S.C. 1395), effective July 1, 1966. The Medicare program is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare (HEW), which has entered into contracts with various insurance companies, such as Blue Cross and Blue Shield organizations, to make payments under the program.

Medicare provides two forms of health protection for eligible beneficiaries aged 65 and over. One form, designated as Hospital Insurance Benefits for the Aged (part A), covers inpatient hospital services as well as posthospital care in an extended-care facility or in the patient's home. Payments for this protection are made from a trust fund financed through a social security payroll tax. Blue Cross is the principal organization that makes part A benefit payments in Michigan.

The second form, designated as Supplementary Medical Insurance Benefits for the Aged (part B), covers physicians' services. Part B benefits are paid from a trust fund financed through premiums paid by beneficiaries electing to participate and matching contributions from funds appropriated by the Federal Government. Effective April 1, 1968, the monthly premium was increased from $3 to $4; effective July 1, 1970, the premium was increased to $5.30. The beneficiary is responsible for paying the first $50 for covered services in each year (deductible) and 20 percent of the reasonable

charges in excess of the first $50 (coinsurance). Michigan Medical Service (Blue Shield) is the organization that makes part B benefit payments in Michigan.[1]

Payments for services provided by supervisory and teaching physicians at teaching hospitals are allowed by SSA regulations under part B. For the services to qualify, the physician must be the Medicare patient's "attending physician," and either render services personally or provide "personal and identifiable direction to residents and interns" participating in the care of the patient. The salary costs of hospital residents and interns under an approved training program are reimbursable to the hospital under part A of the program.

Where physicians are paid salaries by the hospital, SSA regulations authorize part B payments to the hospital for the physicians' personal services to individual hospital patients. To the extent that these hospital-based physicians are compensated by the hospital for services other than direct patient care, such as teaching, research, administration, and supervision of technical personnel, the reasonable cost of these services is reimbursable to the hospital under part A. SSA regulations provide, however, that the sum of the payments to the hospital under parts A and B should be about equal to the amount of the physicians' compensation allocable to the Medicare program except in certain circumstances where, prior to the start of the Medicare program, the hospital's part B charges for physicians' services had been identified separately from the hospital's part A charges for hospital services.

---

[1]The Travelers Insurance Company, operating under a contract with the Railroad Retirement Board (RRB), makes part B benefit payments on a nationwide basis for RRB-related beneficiaries and, accordingly, administers a small portion of the part B Medicare program in the same geographical area covered by Blue Shield.

MEDICAL CARE AND PHYSICIANS' BILLING ARRANGEMENTS AT WAYNE COUNTY GENERAL HOSPITAL

Wayne County General Hospital, operated by the county government, has three divisions--psychiatric, extended care, and general hospital. Our review involved only the general hospital division which has about 430 inpatient beds, has emergency and outpatient facilities, and offers the full range of usual medical services. The hospital is affiliated with the University of Michigan and Wayne State University medical schools.

In 1969, operating expenses of the general hospital division totaled $15 million. About 21 percent of the patient-days were covered under part A of the Medicare program. Medical care in the general hospital division was provided by about 70 salaried staff physicians and 270 residents and interns. The residents and interns were participating in various training programs at the hospital approved by the American Medical Association. About 80 paid medical consultants and about 40 voluntary medical consultants were available to assist the medical staff as needed.

Basis for hospital's charges for physicians' services

Staff physicians at the hospital are county employees and are paid an annual salary. All staff physicians have assigned to the hospital their right to bill and retain funds received for services provided to patients in the hospital. Bills under part B of the Medicare program for physicians' services were made by the hospital in the names of physicians--usually the heads of departments or wards. Blue Shield made payments for these services directly to the hospital.

In August 1969, when Blue Shield curtailed payments to the hospital for part B services, the hospital changed its method of billing for such services. The hospital then began preparing bills for daily care and surgery in the name of individual physicians who certified that they rendered the services. If and when part B payments are resumed, Blue Shield officials advised us that the checks would be issued to the physicians. Hospital officials advised us, however, that

they would then require the physicians to turn the funds over to the hospital.

Fees charged for daily care and surgery from July 1966 through 1967 were based on the suggested fee schedules in the Michigan Blue Shield Physician's Manual. The physicians' part B charges for certain ancillary services, such as for radiology and laboratory work, were based on percentages of the fees shown in these schedules. Starting in 1968, the hospital based its fees on a relative-value study prepared by the Michigan State Medical Society. The hospital considered this study to be a more up-to-date basis for establishing fees. Under a relative-value study, unit values are assigned to each type of medical and surgical service. The hospital determined the fees by multiplying the unit values assigned to the type of service by a rate of $5.

Hospital's disposition of fees received

In April 1964, the Wayne County Board of Supervisors established a fund for hospital staff education and research. A portion of the fund's revenue was to come from fees received for professional services of salaried staff physicians at Wayne County General Hospital.

The fund established by the board of supervisors was designated as the Wayne County General Hospital Medical Staff Research and Educational Fund and was to be used to support the following objectives:

--Continuing and improving the present level of patient care.

--Attracting and retaining well-qualified physicians, residents, and interns.

--Assisting the permanent staff to keep abreast of the rapidly changing techniques and procedures in the medical profession.

--Providing funds for "pilot" research so that research grants may be obtained from national and private agencies.

--Contributing to the advancement of medical knowledge through research.

Fees received by the hospital for physicians' services under part B and from other sources, such as private medical insurance companies, were deposited in the general fund of Wayne County. The county distributed the funds annually--the first $70,000 to the research and development fund and the next $180,000 to the county; any remaining balance was to be distributed in the ratio of 40 percent to the research and development fund and 60 percent to the county.

Part B Medicare payments of $371,000[1] were received by the hospital between March 1967 and June 1969 and related to services rendered since July 1966. The hospital also received $120,000 during the same period from the Michigan State Medicaid program for physicians' services. Most of these Medicaid payments represented the Medicare part B deductible and coinsurance amounts for patients eligible for benefits under both programs.

The hospital reported that, during the 3-year period ended November 1969, total receipts from fees for physicians' services amounted to about $1.7 million. Therefore, payments received under the Medicare and Medicaid programs represented about 30 percent of the total funds received by the hospital for the services of its salaried staff physicians.

---

[1]Of the $371,000 Medicare part B payments received by the hospital, about $5,000 was received from The Travelers Insurance Company for services rendered to RRB-related beneficiaries; the balance of $366,000 was received from Blue Shield.

REVIEW OF MEDICAL RECORDS FOR SERVICES OF SUPERVISORY AND TEACHING PHYSICIANS CHARGED TO THE MEDICARE PROGRAM

Our comparison of the part B bills with the medical records applicable to 50 Medicare patients indicated that the professional services, for which bills on a fee-for-service basis had been made by the hospital in the names of supervisory physicians, generally had been provided by residents and interns and not by supervisory physicians. Services provided by residents and interns were not eligible for billing on a fee-for-service basis under part B of the Medicare program, but their salaries were reimbursable to the hospital under part A of the program. If reimbursement were made under both parts A and B, the Medicare program would be paying twice for the same services.

In most cases the records lacked documentation, as required by SSA regulations and guidelines, to establish whether the patient had an attending supervisory physician who exercised full personal control over the care of the patient during his hospitalization.

SSA regulations issued in August 1967[1] describe the basis for payments for services of supervisory or teaching physicians as follows:

> "(b) Payment on the basis of reasonable charges is applicable to the professional services rendered to a beneficiary by his attending physician where the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of his patient. *** The carrying out by the physician of these responsibilities would be demonstrated by such action as: Reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after admission; confirming or revising

---

[1] The SSA regulations were published in February 1967 in the Federal Register as a proposed rule.

diagnosis; determining the course of treatment to be followed; assuring that any supervision needed by the interns and residents was furnished; and by making frequent reviews of the patient's progress."

In April 1969, SSA issued revised guidelines to set forth more clearly the circumstances under which payments on a fee-for-service basis may be made for the services of supervisory or teaching physicians and the documentation required to support such payments. Some of the more important provisions are as follows:

"The physician[1] must be the patient's 'attending physician.' This means he must *** render sufficient personal and identifiable medical services to the Medicare beneficiary to exercise full, personal control over the management of the portion of the care for which a charge can be recognized; his services to the patient must be of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients.

* * * * *

"3. Performance of the activities *** must be demonstrated, in part, by notes and orders in the patient's records that are either written by or countersigned by the supervising physician."

"[1]The term 'physician' does not include any resident or intern of the hospital regardless of any other title by which he is designated or his position on the medical staff."

From March 1967 to June 1969, the hospital received about $371,000 in part B payments for the services rendered since July 1966 to Medicare patients by its salaried staff physicians, including such specialists as radiologists and pathologists. We selected 50 patients at random for whom part B payments of $8,140 had been made by Blue Shield. Of

these payments, $6,719 was for daily care, surgery, and consultations and $1,421 was for radiology, electrocardiograms, and pathology (laboratory) services.

The part B charges for the latter three types of services ranged from 5 to 25 percent of the total hospital charge. The total hospital charge included (1) the hospital's costs for the salaries of technical personnel and the cost of supplies and equipment which are reimbursable under part A and (2) the "professional component" or fees for physicians' personal services to patients which are reimbursable under part B. We did not review the charges for radiology, electrocardiograms, or pathology services because the SSA regulations dealing with supervisory or teaching physicians were not applicable to physicians who provide these types of specialized services.

For the hospital's charges for daily medical care, surgery, and consultations that involved payments of $6,719, or about 83 percent of the payments made on behalf of the 50 patients, we compared the bills with the patients' medical records and hospital reports to determine the extent that these records showed the involvement of the physician in whose name the bill was submitted. The bills we reviewed had been submitted to Blue Shield by the hospital from April 1967 through October 1969.

The types and numbers of services and the amounts billed by the hospital and allowed by Blue Shield for the 50 patients are summarized below:

	Occasions of service	Amount billed	Amount allowed by Blue Shield
Daily medical care	485	$2,881	$2,764
Surgery	28	6,383	6,050
Consultations	7	120	120
Total	520	$9,384	8,934
Less deductibles and coinsurance payable by patients			2,215
Total payments reviewed			$6,719

Because of the technical nature of the data, hospital administrative and medical personnel and a Blue Shield consulting physician provided us with professional assistance in our examination of the medical records. Our findings are discussed as follows:

Daily medical care

For the part B payments we reviewed, Medicare was billed in the name of a supervisory or teaching physician for daily visits for medical care for each day the patient was hospitalized, except for the surgical cases in which the preoperative and postoperative days of medical care were included in the charges for surgery. The daily visits were billed as follows: $15 for the first day which included a medical diagnosis, physical examination, and preparation of the patient's medical history; $5 for days 2 through 21; and $4 for each additional day.

The bills pertaining to the 50 patients showed that the hospital billed Blue Shield $2,881 for 485 daily visits. Hospital and medical records containing doctors' orders, progress notes, and nursing notes did not contain documentation confirming that 108 of the 485 daily visits had been made. Records showed that most of the remaining 377 daily visits, which were supported by physicians' notations, had been made only by residents and interns. The records showed also that the supervisory or teaching physicians in whose names the bills had been submitted had been involved in only 15 of the 377 daily visits. There were five visits in which other supervisory and teaching physicians had been involved in providing daily care. For the remaining 357 daily visits, notations in the records showed that care had been rendered by residents, interns, or students; but countersignatures or other evidence of direction by supervisory physicians were absent.

The hospital medical director agreed that there was a lack of documentation but stated that the absence of a physician's notation did not necessarily mean that a supervisory physician did not visit patients or review cases. She emphasized that physicians did not have time to record all they had done for a patient during each day.

Surgery

Medicare was billed $6,383 for physicians' services in connection with 28 operations performed on 17 of the 50 patients. The hospital records, such as the operating room reports, showed that eight of the operations involving charges of about $2,150 had been performed by residents and there was no indication as to whether a supervisory physician was present during surgery. The charges for these eight operations--including three cataract extractions, one leg amputation, and one repair of a broken hip--ranged from $150 to $375. In our opinion, these eight charges should not have been allowed because the SSA regulations dealing with part B payments for the services of supervisory and teaching physicians who supervise residents and interns provide, in part, that:

> "In the case of major surgical procedures and other complex and dangerous procedures or situations, such personal and identifiable direction must include supervision in person by the attending physician ***."

Our findings with respect to the remaining 20 operations for which the hospital medical records showed that supervisory or teaching physicians were involved are summarized as follows:

- For 13 of the operations involving charges of $2,455, the supervisory physicians in whose names the bills had been submitted were shown as the principal surgeons and usually residents and interns were shown as assistants.

- For four of the operations involving charges of $1,215, residents were shown as the principal surgeons and the supervisory physicians in whose names the bills had been submitted were shown as the assistants.

- For three of the operations involving charges of $563, residents had performed the operations and the physicians in whose names the bills had been submitted were shown as being present during the surgery.

Consultations

The medical records supporting the seven consultations involving charges of $120 showed that in each case the supervisory physician in whose name the bill had been submitted had also been involved in providing the service.

Actions taken to implement SSA's April 1969 guidelines relating to payments to supervisory and teaching physicians

The revised SSA guidelines issued in April 1969 were intended to clarify and supplement the criteria for making payments for services of supervisory and teaching physicians. SSA stated that new guidelines would be necessary because of an apparent serious need for a better and more uniform understanding by all concerned of the conditions under which such payments could be made.

Blue Shield received the revised guidelines in May 1969 and distributed them to all Michigan hospitals on June 30, 1969. In August 1969, Blue Shield curtailed Medicare part B payments to 16 teaching hospitals in Michigan, including Wayne County General Hospital, and subsequently scheduled audits of the hospitals to determine whether they were complying with the new guidelines.

In December 1969, Blue Shield auditors reviewed 100 patients' medical records at Wayne County General Hospital and concluded that the hospital was not complying with the revised guidelines because they found that medical records for 74 of the patients did not support the bills submitted to them. The auditors' findings are summarized below.

Number of records	Blue Shield auditors' findings
74	Medical records did not identify the physicians in whose names bills had been submitted as having been involved in providing the services.
18	Medical records showed that physicians in whose names the bills had been submitted had also been involved in providing the services.
8	At time of review, bills had not been prepared.
100	

The auditors recommended to Blue Shield officials that part B payments to Wayne County General Hospital not be resumed until the record problems were resolved and that SSA and the intermediary under part A (Blue Cross) be consulted to determine if any part B funds already paid should be refunded. As of October 1, 1970, Blue Shield had not resumed part B payments to the hospital.

Hospital, Blue Shield, and SSA comments concerning GAO review of the medical records

In commenting on a draft of this report, the hospital stated, in part, that:

> "We have reviewed the clinical records of the patients identified to us as those audited by your staff ***.
>
> "Regrettably, our review of the aforementioned clinical records does not enable us to refute the findings reported *** that our Medical Staff has not documented in the clinical records that they provided all of the services for which bills were rendered. This does not mean that the services were not rendered. It does mean, however, that our Medical Staff cannot confirm by means of the clinical records that the services were rendered.
>
> "The conclusion indicated *** that the professional services for which Medicare billings were rendered 'generally had been furnished by residents and interns and not by an attending physician' is considered erroneous by our Director of Medicine and our Director of Surgery."

In our opinion, the hospital's comments are indicative of the problems inherent in paying for medical services on a fee-for-service basis in an institutional setting where residents and interns are involved in providing day-to-day care.

On one hand, the individual or organization charging on the basis of a fee for a specific service provided to a patient by a specific physician cannot confirm that the service was provided. On the other hand, an organization expected to pay for such a service cannot prove that the service was not

provided. Under these circumstances, we believe that a more appropriate basis for payment would be to pay for a proportionate share of the salaries and fringe benefits of the physicians rendering or supervising the medical care of Medicare beneficiaries as is done when services are provided by residents and interns.

In commenting on a draft of this report, Blue Shield acknowledged that, partially because the hospital's medical records generally did not support the payments we reviewed, a fee-for-service basis for reimbursing the hospital for the services of its salaried supervisory physicians under part B of Medicare might not have been the most appropriate payment method.

Blue Shield indicated also that the fee-for-service basis might not have been the most appropriate payment method (1) because, prior to January 1969, the Medicaid program which covered a sizable portion of the hospital's patients had not made payments for the physicians' services at the hospital on a fee-for-service basis (see p. 19) and (2) because the hospital's salaried physicians did not have sufficient outside private practice to establish that the fees charged the Medicare program by the hospital were the physicians' customary charges.

Blue Shield stated that it had concluded that a more appropriate basis for payment for physicians' professional services at Wayne County General Hospital would be a per diem rate for each day of hospitalization.

In our opinion, if such a per diem rate were based on the hospital's cost of providing these services, this method would be a reasonable one.

SSA advised us that we had been correct in our conclusion that part B payments on a fee-for-service basis were not appropriate at Wayne County General Hospital.

NEED TO ENSURE THAT PAYMENTS TO HOSPITAL UNDER PARTS A AND B DO NOT EXCEED ITS REIMBURSABLE COSTS

On the basis of claims submitted by the Wayne County General Hospital under part A of the Medicare program, we estimate that the amounts claimed under part A and the amounts paid under part B for the inpatient services provided by its salaried physicians exceeded the hospital's reimbursable costs by as much as $115,000 for the 3-year period ended June 30, 1969.

Because Blue Shield and SSA concluded that, in view of the circumstances discussed in this report, the fee-for-service basis for billing under part B of the Medicare program for physicians' services was not the appropriate basis for payment at Wayne County General Hospital, we believe that the part B payments to the hospital--including the deductible and coinsurance amounts payable by the Medicare patients--should be limited to the hospital's reimbursable costs of providing physicians' services. Under this approach the hospital would neither gain nor lose with respect to the services already furnished to Medicare patients.

Amounts claimed for physicians' services under part A

Under part A of the Medicare program, hospitals are to be reimbursed for the reasonable costs of providing services to Medicare patients. As determined under SSA's reimbursement regulations, intermediaries, such as Blue Cross, make payments to hospitals on an estimated basis at least monthly. These payments, however, are adjusted annually after the intermediaries audit the claims for reimbursement (cost reports) submitted by the hospitals and make final cost settlements with the hospitals.

As of August 15, 1970, Blue Cross had not made any final cost settlements with Wayne County General Hospital for any accounting periods since the inception of the Medicare program in July 1966. Further, no audits of the hospital's cost reports had been completed by the intermediary. The hospital had, however, submitted cost reports to the intermediary for the 6-month period ended December 31, 1966, and for each of the years ended December 31, 1967, 1968, and 1969.

The portion of the compensation paid by the hospital to its salaried physicians which was related to services other than direct patient care (e.g., teaching, research, administration, and supervision) was reimbursable to the hospital under part A. Therefore in developing its cost reports to claim

reimbursement under part A, that portion of the physicians' salaries and fringe benefits allocable to direct patient care (part B services) was to be deducted from the hospital's total costs.

For the 3-½-year period ended December 30, 1969, the hospital deducted about $1,637,000, or about 40 percent of its total physicians' salary and fringe benefit costs, from the costs of which a portion was to be allocated to part A of the Medicare program. These deductions were applicable to all the salaries and fringe benefits of all the hospital's physicians including the radiologists and pathologists. During this period, the hospital provided about 485,000 patient-days of care. The hospital's deduction for the cost of direct patient care provided by its physicians from its claim for reimbursement under part A, therefore, was equivalent to about $3.37 a patient-day.

According to the hospital's Medicare cost reports and other records, a total of 105,681 patient-days of care were provided by the hospital to Medicare patients from July 1, 1966, through June 30, 1969. Therefore, the hospital deducted the equivalent of $356,000 from its claims for reimbursement under part A for the part B services provided to Medicare inpatients.

Under part B, both the beneficiary and the Medicare program are responsible for paying a portion of the physicians' charges--the beneficiary for the first $50 (deductible) and 20 percent of the remaining charges (coinsurance). The Medicare program pays for the balance. On the basis of SSA nationwide statistics, the beneficiaries' and the program's portions of the charges were about 28 percent and 72 percent, respectively, during the 3-year period ended June 30, 1969. These nationwide statistics may not be representative of the beneficiaries' and program's portions of the physicians' charges at Wayne County General Hospital. Using this basis, however, we estimate that, of the $356,000 deducted by the hospital from its claims for reimbursement under part A, only about $256,000, or 72 percent, represents the hospital costs reimbursable under part B of the program.

Amount paid for physicians' services under part B

For the 3-year period ended June 1969, the hospital received Medicare part B payments of about $371,000 for physicians' services including the amounts collected for services provided by its radiologists and pathologists which had been billed as percentages of the hospital's total charges.

Because of the time lag between the dates of service and receipt of payment, however, this amount does not include payment for all physicians' services provided through June 1969 to all Medicare patients eligible for part B coverage. Nevertheless, the part B payments of $371,000 received by the hospital were about $115,000 more than the estimated reimbursable part B costs of $256,000. Accordingly, the hospital has received a potential profit or windfall of as much as $115,000 from its bills for all physicians' services under part B of Medicare, including daily care, surgery, consultations, radiology, electrocardiograms, and pathology.

Hospital and Blue Shield comments

In commenting on a draft of this report, the hospital pointed out that the costs applicable to physicians' part B services which had been deducted from its claims for reimbursement under part A for the 6-month period ended December 31, 1966, were seriously understated and that claims for other periods were inaccurate. The hospital advised us that, inasmuch as Blue Cross was making an audit of the hospital's costs for the period covered by our review, the hospital would wait until the completion of the audit to determine the correct allocation of the costs of physicians' salaries and fringe benefits between parts A and B of the Medicare program.

The hospital advised us also that its medical staff objected to the SSA reimbursement regulation (see p. 2) which provided that the charges for the services of salaried hospital-based physicians under parts A and B of the Medicare program should be about equal to the amount of the physicians' compensation allocable to the Medicare program. The hospital stated that its medical staff members believed that the fees for their services should be established in the same manner as the fees of their colleagues in private practice.

Blue Shield advised us that it would be in a position to make a more accurate assessment of the situation when the results of the Blue Cross audit of the hospital's cost reports became available.

Although we agree with the hospital that the deduction for physicians' part B services on its cost report for the 6-month period ended December 31, 1966, was understated and that its other reports also were inaccurate, we believe that the part B payments discussed in this report should be considered by Michigan Blue Cross and Blue Shield in their audits of the hospital's cost statements and any excess payments should be recovered in reaching a settlement with Wayne County General Hospital for reimbursement under both parts A and B of the program.

PATIENTS INVOLVEMENT IN PAYMENTS MADE ON THEIR BEHALF

For the 50 patients included in our sample, about 65 percent of the deductible and coinsurance amounts applicable to the charges for physicians' services were collected by the hospital primarily from the Medicaid program or from Blue Shield under its commercial insurance policies which supplemented Medicare. Because the patients, at the time of admission, had authorized the hospital to bill for any benefits due on their behalf, they were not required under SSA regulations to sign each bill authorizing payment to be made to the hospital for the services of specific physicians. The patients were notified, however, by Blue Shield of payments made on their behalf.

Extent to which patients paid for deductibles and coinsurance under part B

The 50 patients were responsible for paying deductibles and coinsurance amounting to $2,215 of the charges of $8,934 allowed for daily care, surgery, and consultations. The hospital attempted to collect the $2,215 from the Medicaid program, insurance companies, and the patients; as of May 1, 1970, $1,469, or about 65 percent, had been collected by the hospital as summarized below.

	Bills submitted by hospital		Payments received	
To	Number	Amount	Number	Amount
Medicaid program	30	$1,206	27	$ 913
Blue Cross and Blue Shield complementary insurance for persons aged 65 or over	12	529	9	361
Other private insurance	4	197	3	195
Patients	4	283	-	-
Total	50	$2,215	39	$1,469

Patient signature on each part B bill not required

Because the part B payments made to the hospital by Blue Shield were for the services of physicians on whose behalf the

hospital had made arrangements to collect the charges for individual patient care, the patients were not required by SSA regulations to sign each bill. Instead, the hospital required patients, at time of admission, to sign the following statement authorizing the hospital to bill for any benefits due on their behalf:

> "I promise to pay Wayne County General Hospital, upon demand, all obligations incurred by the above named patient for services on dates indicated above. I certify that the information given by me in applying for payment from any insurance company or under Titles XVIII or XIX of the Social Security Act is correct. **I authorize release of any information from the patients' hospital records needed to act on this request. I authorize payment for any** benefits due in behalf of the named patients to be made to Wayne County General Hospital."

On each bill, the hospital made a notation that the patient's signature was on file rather than having the patient sign the bill.

In August 1969, after Blue Shield had curtailed part B payments to the hospital, the hospital changed its billing procedures and began using a Medicare billing form which generally requires that the patient authorize payments to be made for the services of specific physicians each time a bill is submitted.

Patient notification of part B payments

SSA regulations require organizations, such as Blue Shield, making benefit payments under part B to furnish Medicare beneficiaries with explanations identifying individuals or organizations receiving payments made on behalf of the beneficiaries, the place and date of services, and charges allowed. We found that Blue Shield had furnished the required explanations to Medicare patients at Wayne County General Hospital.

EXTENT TO WHICH PAYMENTS--OTHER THAN MEDICARE--ARE NORMALLY MADE FOR SERVICES OF SUPERVISORY AND TEACHING PHYSICIANS

We also inquired into the hospital's billing practices involving the services provided by its salaried supervisory and teaching physicians to non-Medicare patients. We were informed by hospital officials that, before the Medicare program began (July 1966), the hospital had billed private insurers on a fee-for-service basis for physicians' services. Effective in January 1969, the hospital began billing the Medicaid program for physicians' services on a fee-for-service basis for those patients eligible for benefits only under that program. These charges were in addition to collections from Medicaid for the deductible and coinsurance amounts applicable to Medicare patients who were also eligible for Medicaid. Before January 1969, the hospital had billed the Medicaid program on the basis of an all-inclusive per diem rate that covered both hospital and physicians' services.

Hospital records show that most patients discharged during the 6-month period ended June 30, 1969, had some type of medical insurance protection or were otherwise eligible for financial assistance. About 75 percent of the patients with private insurance were covered by Blue Cross and Blue Shield. Our test of bills to private insurers showed that the hospital charged the same fees for like services that Medicare had been billed. In most cases, the private insurance companies honored the hospital's bills. Further as stated on page 5, for the 3-year period ended November 1969, the hospital reported that payments from the Medicare and Medicaid program represented only about 30 percent of the total funds received by the hospital for the services provided by its salaried staff physicians.

United States Senate
COMMITTEE ON FINANCE
WASHINGTON, D.C. 20510

May 7, 1970

The Honorable
Elmer B. Staats
Comptroller General
of the United States
Washington, D. C.

Dear Mr. Staats:

I understand that your office has been making reviews of Medicare payments for the services of supervisory and teaching physicians at five hospitals which are similar to the review made at the request of this Committee of Medicare payments to supervisory and teaching physicians at Cook County Hospital in Chicago, Illinois. I also understand that your Office contemplates issuing an overall report to the Congress presenting the findings, conclusions, and recommendations developed in connection with the reviews at the five hospitals.

On May 4, 1970, the Committee on Ways and Means of the House of Representatives announced that, in connection with its consideration of amendments to title XVIII of the Social Security Act, it had proposed certain restrictions with respect to payments under the supplementary medical insurance (part B) portion of the Medicare program to supervisory and teaching physicians.

This Committee will soon consider legislative changes concerning Medicare payments to supervisory and teaching physicians. In connection with this work, would you please furnish to this Committee individual reports of these reviews.

Although it will not be necessary for you to develop overall conclusions and recommendations relating to this information, the material furnished to this Committee should at least cover the following points with respect to the payments made on behalf of selected Medicare beneficiaries:

1. The extent that the services paid for were furnished by the supervisory or teaching physician in whose name the services were billed, by other attending physicians, or by residents and interns, as shown by the hospitals' medical records. Also, information as to any changes in billing or record-keeping practices since the implementation of Social Security's April 1969 guidelines relating to such payments.

2. The extent to which payments made from Medicare (part B) funds represented payments for services of physicians whose compensation may have also been reimbursed in part to the hospitals under the hospital insurance (part A) portion of Medicare. For those physicians who were not compensated by the hospitals, information as to their medical school affiliations and the bases for their compensation by these institutions would be helpful.

3. Information as to whether the individual physicians bill for claimed services or whether the billing is done by the hospital or some other organization, and information as to the disposition of such funds obtained from part B of the Medicare program. For example, are the payments retained by the physician or are they turned over to the hospital, medical school, or some other organization.

4. Whether: (a) the Medicare patients were billed for and subsequently paid the deductible and coinsurance portions of the Medicare charges, (b) the patients signed the appropriate claims forms requesting that Medicare payments be made on their behalf, and (c) the patients received "explanations of benefits" or other notification of the payments made on their behalf.

5. Information as to the basis for arriving at the amounts of "reasonable charges" for the services paid for.

6. Information as to whether any other medical insurance programs or other patients regularly made payments for services provided by the supervisory and teaching physicians at the hospitals in amounts comparable to those paid from Medicare funds under comparable circumstances.

7. Information as to the steps taken by the hospitals and the carriers to obtain compliance with SSA's April 1969 guidelines concerning payments to supervisory and teaching physicians, including actions taken to suspend or recover payments.

8. Any other pertinent information which you believe would be helpful to this Committee in its consideration of the subject.

Although there is no need to obtain formal advance comments from the Department of Health, Education and Welfare, the Committee has no objection to your Office discussing the matters covered in the reports with appropriate officials of the Department.

With every good wish, I am

Sincerely,

Chairman